Lady Gowrie QLD Community Kindergartens

Ongoing Medication Permission Form

In the interest of children's safety and wellbeing, the education and care service will only administer medication if it is in its original container with the dispensing label attached, the label should list the child as the prescribed person, the strength of drug and the frequency it is to be given.

Only a Parent / Guardian or Authorised Nominee as named in the Child's enrolment record as authorised to consent to the administration of medication to the child can complete this permission form

Please Note: An Ongoing Medication Permission Form Must be Completed in Conjunction with a Current Asthma / Allergy / Diabetes Management Plan or Ongoing Medical Condition Management Plan.

Child's Full Name:____Child's Date of Birth: ____________

Medical Practitioner/Pharmacist etc.: ____

Medication Information:

Name of Medication: ____

Date Prescribed: ____

Expiry Date of Medication: ____

Reason for Medication: ____

Storage Requirements: ____

Time and Date the medication was last administered: ___________________________________

I request that the above medications be administered in accordance with the instruction below or the circumstances under which, the medication should next be administered are (if applicable include date, time and dosage amount required to be administered): ____

____

____

Or

◯ Administration as per Medical Management Plan or Medical Letter Attached.

Instructions for the manner in which the medication is to be administered: e.g. Route (oral, inhaler), dose (e.g. Thin layer, number of drops / mls / tablets), before or after food:

____

____

Parent / Guardian / Authorised Nominee Full Name ______________________________________

Date:___/___/___ Signature ____

(Staff are to complete the table on next page each time the medication is administered form is to be printed back to back or stapled together)

Second page of Medication Permission Form for (Child's Full Name): ____

Staff to complete on administration of medication:

Date	Dosage Administered	Time to be Administered	Time actually Administered	Manner in which medication was administered (e.g. oral liquid, thin layer cream, inhaler).	Name of staff administering medication	Signature of staff administering medication	Name of staff who cross-checked dosage and administration of medication	Signature of staff cross-checked dosage and administration of medication	Comments

Where additional rows are required to record administration throughout the year these must be stapled to the original permission form.